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Robert Sillen

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants.

Case No. C01-1351 TEH

DECLARATION OF TERRY HILL, M.D. IN SUPPORT OF RECEIVER'S SUPPLEMENTAL APPLICATION NO. 2 FOR ORDER WAIVING STATE CONTRACTING STATUTES, REGULATIONS AND PROCEDURES, APPROVING RECEIVER'S SUBSTITUTE PROCEDURE FOR BIDDING AND AWARD OF CONTRACTS

I, Terry Hill, declare as follows:

1. I am currently the Chief Medical Officer for the California Prison Health Care Receivership and make this declaration in support of the Receiver's Supplemental Application No. 2 for a Waiver of State Contracting Procedures. The facts set forth herein are based on my own personal knowledge and, if called as a witness, I could competently testify thereto.

2. I received my B.A. in Literature from Reed College in 1974 and an M.D. from the University of California, San Francisco in 1987. From 1987 to 1991, I was first a Resident in Primary Care Internal Medicine and then Chief Resident in Internal Medicine at Highland General Hospital in Oakland, California. From 1991 to 1993, I was a Fellow in Geriatrics at Stanford University and the Palo Alto Veterans Administration Medical Facility. I was a National Institute of Health Postdoctoral Research Fellow at Stanford University from 1993 to 1994. From 1994 to the present, I have been on the medical school faculty at Stanford University and since 2000, I have been an Assistant Clinical Professor in the Department of Medicine at the University of California, San Francisco. I also serve on the Advisory Boards of the Northern California Geriatric Education Center and the Northern California Geriatric Education Center. In addition to my academic affiliations discussed above, I was in private practice as a geriatrician from 1994 to 1999.

3. I have also served as the Medical Director of a hospitalist physician group at Summit Medical Center in Oakland California, the Medical Director of Laguna Honda Hospital and Rehabilitation Center in San Francisco, as well as the Medical Director and Senior Medical Director for Quality Improvement at Lumetra.

4. More recently, I served this Court as a Medical Expert in both *Madrid v. Schwarzenegger* and in this action. Since 2006, I have been employed by the Receiver as his Chief Medical Officer. I have served in various capacities with numerous community and professional organizations pertaining to medical care, and have authored many articles and spoken at conferences on various issues in health

care and the improvement of the delivery of health care services.

5. **The Receiver's Quality Improvement ("QI") program, including specifically the Asthma Initiative.** In 2003, as part of the *Plata* remedial program, the CDCR introduced a nominal chronic care program to address the deficiencies of the sick call model of primary care. Inmates with one of nine conditions were to be enrolled as chronic care patients and seen at regular intervals by qualified providers. The *Plata* remedial program was a failure on many fronts for many reasons, including inadequate medical records, almost non-existent information technology, and a shortage of qualified clinicians and managers.

6. In the Findings of Fact and Conclusions of Law ("FFCL"), dated October 3, 2005, this Court concluded that very significant numbers of preventable deaths occurred in the prisons each year, as many as one every six or seven days. FFCL, pp. 10-13. In his efforts to address these fundamental problems, the Receiver and his staff are rapidly deploying healthcare information technology and a sophisticated pharmacy management system, and hiring increasing numbers of qualified clinicians and managers. For example, the Pharmacy and Therapeutics Committee has adopted medication guidelines for acute and chronic asthma based on the National Asthma Education and Prevention Program Expert Panel Report (Update 2002).[1] But the CDCR still lacks a quality improvement infrastructure, clinicians are unfamiliar with process redesign, and episodic care rather than planned care is still the norm. There is still no care coordination or case management program, no decision support, and precious little patient education.

7. In fact, an analysis of all CDCR inmate-patient deaths occurring in 2006 revealed that serious problems still remain. According to that analysis, there were 18 preventable deaths and as many as 48 possibly preventable deaths.[2] The study concluded that

[1] NIH National Asthma Education and Prevention Program. Expert panel report: guidelines for the diagnosis and management of asthma: update on selected topics 2002. Available at http://www.nhlbi.nih.gov/guidelines/archives/epr-2_upd/index.htm.

[2] California Prison Health Care Receivership Corporation. Prison Medical Care System Reform: Plan of Action. May 2007. See www.cprinc.org/materials.htm.

asthma accounted for the single highest number of preventable deaths. The analysis goes on to describe the system inadequacies and imperatives for change:

> CDCR medical staff has been working in an environment of care characterized by crowded and poorly equipped clinical areas. The medical record systems are outdated and medical information is difficult to retrieve. The dispensing of prescribed drugs is often delayed, and there is an unreliable system for refilling medications for the treatment of chronic medical diseases such as diabetes, hypertension, asthma and coronary heart disease. The drug profile information is unreliable. Practices in many of the prisons focus on episodic care rather than continuity of care and preventive medicine. The environment does not guarantee patient confidentiality, and the culture does not promote patient advocacy.
>
> The CDCR must create a culture of patient safety, in which clinicians readily identify mistakes and system vulnerabilities and in which all staff share in the responsibility for optimal patient outcomes. Systems should be reviewed or redesigned to support this end.

8. The analysis concludes with a number of recommendations for quality improvement initiatives, which the Receiver anticipates implementing in the coming months and years. Because asthma figured so prominently in the deaths, the analysis recommended that asthma be the focus of the first full-fledged quality initiative.

9. *Description of the Project.* The Receiver's Plan of Action[3] draws heavily from work by the Institute of Medicine ("IOM") over the past decade in response to the quality crisis within mainstream American health care. According to the IOM, health care should be safe, effective, patient-centered, timely, efficient, and equitable. The IOM has endorsed adoption of chronic care programs.

10. The Chronic Care Model[4] includes a number of interlocking components that together encourage high-quality chronic disease management. The Chronic Care Model has been successfully implemented in settings serving uninsured patients, the homeless, migrants, and minority populations, often using the Model for Improvement promulgated by the Institute for Healthcare Improvement.[5]

11. In keeping with the recommendations of the 2006 inmate death analysis, as the first of

[3] California Prison Health Care Receivership Corporation. Prison Medical Care System Reform: Plan of Action. May 2007. See www.cprinc.org/materials.htm.

[4] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.

[5] See: How to Improve at www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprov.

a series of planned QI programs, the Receiver is undertaking an Asthma Initiative. The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. It will also provide a testing ground for implementation of interdisciplinary QI projects. For example, the initiative will engage all six of the organizational change strategies that the IOM considers necessary to improve health care: (a) redesign of care processes based on best practices; (b) use of information technology for clinical information and support for caregivers; (c) increasing and deepening clinical knowledge and skills (d) development of a team-based, rather than a physician-centric, delivery system; (e) coordination of care; and (f) incorporation of performance and outcome measurements for improvement and accountability.

12. In addition, the Asthma Initiative will demonstrate how to use data to inform the clinical care redesign process while orienting our providers and management staff to patient safety issues. The end result of this specific disease management initiative will be a heightened awareness of chronic disease management leading to the improved care of other conditions and the beginning of a safety culture.

13. The focus of the Asthma Initiative will be full-fledged, real-world practice redesign. The initiative leaders and ground-level clinicians must work together to address a multitude of issues to redesign the processes of care. For example, there is no mystery with regard to the need to assess the breathing capacity of asthma patients at each visit, but in the CDCR there is no agreement as to how to do so. Who will do the assessments, and how? Who will do the documentation, and how should verbal communication occur between patient and nurse, nurse and physician, physician and patient? What is the role of a respiratory therapist? How can we assure that information flows from on-site urgent care, off-site emergency department, or off-site consultant back to the yard clinic at the next appointment? More specifically, how should we address these questions now—in a system with chaotic medical records, pharmacies and laboratories, in which nurses and physicians have rarely worked

together in teams, and in which custody and healthcare staff have often worked at cross purposes?

14. In order to achieve significant practice change and clinical improvement, the Asthma Initiative will involve headquarters, regional, and institutional staff, pharmacy/Maxor staff, and the external clinical and organizational change consultants. The local interdisciplinary teams will include provider, nursing, pharmacy, health records, and clerical staff. Each local interdisciplinary team will be lead by a clinical champion well-respected by his/her peers. The external clinical change experts will provide a change package, project management, and QI technical support. The project will follow established clinical guidelines. The pharmacy information system will identify patients using asthma medications. Data on medication usage will help stratify patients by severity.

15. The Asthma Initiative design will derive from the original Breakthrough Series Learning Collaboratives.[6] Adaptations of the collaborative model have proven to be effective and efficient.[7] The initiative will engage a small number of facilities initially, but staff from all 33 prisons should have the opportunity to participate in the initiative within a year. The initial Asthma Initiative sites will be selected based on local leadership capacity, organizational resource availability, pharmacy stability, and prior implementation of a pharmacy information system, all factors that will also contribute to success in the Asthma Initiative. The pilot sites chosen will have been exposed to QI tools and process redesign; therefore, these sites are most likely to embrace a QI collaborative pilot and the chronic care model.

16. Although the CDCR's 33 prisons often differ in their patient populations, organizational cultures, and clinical effectiveness, they share a core set of policies and procedures. Their limited heterogeneity and autonomy should allow faster

[6] The Breakthrough Series: IHI's Collaborative model for achieving breakthrough improvement. (2003) Boston, Massachusetts: Institute for Healthcare Improvement.

[7] Gould DA, et al. New York City Palliative Care Quality Improvement Collaborative. *Joint Commission Journal on Quality and Safety*. 2007: 33;307.

dissemination of practice improvement than could be achieved among separate organizations.

17. *Description of the contracts necessary to implement the Project.* As part of its overall QI project, the Receiver plans to undertake contracts with organizations and consultants for technical assistance, project management, education, training, evaluation and consultation for the design and implementation of QI peer review and leadership programs, including chronic care management, coordination of care, care process redesign, utilization of management and incorporation of performance and outcome measurements for improvement and accountability.

18. Specifically with respect to the Asthma Initiative, the Receiver has issued a Request for Proposal ("RFP") for technical assistance, education and training, and evaluation services. A true and correct copy of the RFP is attached hereto as Exhibit A. The selected contractor will be engaged to lead an interdisciplinary initiative with CDCR staff aimed at eliminating preventable patient deaths due to undiagnosed or uncontrolled asthma. The Receiver has made it clear in the RFP that the contract cannot be awarded unless and until this Court approves the waiver of contracting procedures requested in this application.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: November 19, 2007

/s/
Terry Hill, M.D.

I hereby attest that I have on file all holograph signatures for any signatures indicated by a "conformed" signature (/s/) within this efiled document.

/s/
Martin H. Dodd
Attorneys for Receiver Robert Sillen

EXHIBIT A

CALIFORNIA PRISON HEALTH CARE RECEIVERSHIP CORPORATION
OFFICE OF THE RECEIVER

REQUEST FOR PROPOSALS

ASTHMA INITIATIVE

FOR CALIFORNIA ADULT PRISON FACILITIES

October 24, 2007

PROPOSALS DUE: 2:00 p.m., December 7, 2007

CONTACT: TERRY HILL, M.D., CHIEF MEDICAL OFFICER
1731 Technology Drive, Suite 700
San Jose, CA 95110
terry.hill@cprinc.org

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I. REQUEST

The Receiver of the California Department of Corrections and Rehabilitation's ("CDCR") prison medical system is requesting proposals for technical assistance, education and training, and evaluation services. The selected contractor will be engaged to lead an interdisciplinary initiative with CDCR staff aimed at eliminating preventable patient deaths due to undiagnosed or uncontrolled asthma. The contract awarded by the Receiver will be a service agreement with either the California Prison Health Care Receivership Corporation ("CPR") or the CDCR.

II. BACKGROUND OF THE RECEIVERSHIP

As a result of the State of California's ongoing failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California has established a Receivership to assume the executive management of the California prison medical system and raise the level of care up to constitutional standards. On February 14, 2006, the Court appointed Robert Sillen to serve as the Receiver and granted him, among other powers, the authority to exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system.

The Court's actions stem from the case of *Plata v. Schwarzenegger* -- a class action law suit brought on behalf of the CDCR's adult inmates. Applicants should refer to the Court's October 3, 2005 "Findings of Fact and Conclusions of Law Re Appointment of Receiver" and the Court's February 14, 2006 "Order Appointing Receiver" for further information regarding the conditions underlying the Receivership and the powers and responsibilities of the Receiver. These and other relevant documents can be found on CPR's website at: http://www.cprinc.org/materials.htm.

III. ANTICIPATED SCOPE OF SERVICES

A. Clinical Background

In 2003 as part of the Plata remedial program, the CDCR introduced a nominal chronic care program to address the deficiencies of the sick call model of primary care. Inmates with one of nine conditions were to be enrolled as chronic care patients and seen at regular intervals by qualified providers. A one-page guideline for "pulmonary disease" included mention of peak flow measurement, theophylline levels, vaccinations, and smoking cessation.

The Plata remedial program was a failure on many fronts for many reasons, including inadequate medical records, almost non-existent information technology, and a shortage of qualified clinicians and managers. Sobering evidence of that failure can be found in the six asthma deaths that occurred in California prisons in 2006. While not all of the deaths may have been preventable, it was clear from quality reviews that system factors and provider practice contributed to at least several of the deaths.

CPR is rapidly deploying healthcare information technology and a sophisticated pharmacy management system, and CDCR is hiring increasing numbers of qualified clinicians and managers. The Pharmacy and Therapeutics Committee has adopted medication guidelines for acute and chronic asthma based on the National Asthma Education and Prevention Program Expert Panel Report (Update 2002).[1] But the CDCR still lacks a quality improvement infrastructure, clinicians are unfamiliar with process redesign, and episodic care rather than planned care is still the norm. There is still no care coordination or case management program, no decision support, and precious little patient education.

B. The Way Forward

The Receiver's Plan of Action[2] draws heavily from the past decade of work by the Institute of Medicine (IOM) in response to the quality crisis within mainstream American health care. According to the IOM, health care should be safe, effective, patient-centered, timely, efficient, and equitable. The IOM has endorsed adoption of chronic care programs.

The Chronic Care Model[3] provides a proven framework for implementation of the asthma guidelines. It includes six fundamental areas, illustrated below, comprising a system that encourages high-quality chronic disease management.

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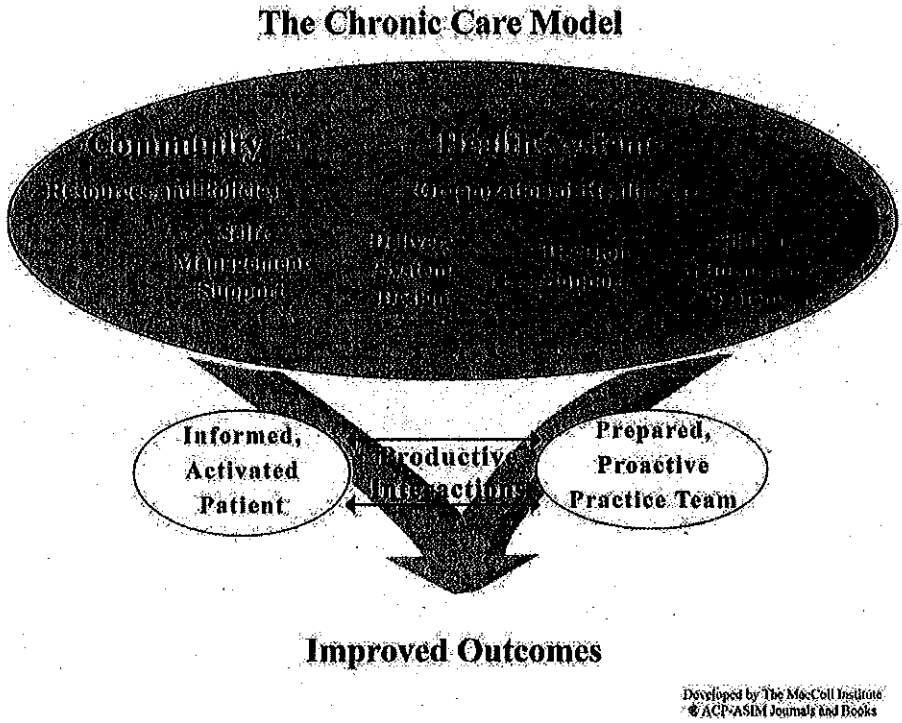
[1] NIH National Asthma Education and Prevention Program. Expert panel report: guidelines for the diagnosis and management of asthma: update on selected topics 2002. Available at http://www.nhlbi.nih.gov/guidelines/archives/epr-2_upd/index.htm.

[2] California Prison Health Care Receivership Corporation. Prison Medical Care System Reform: Plan of Action. May 2007. See www.cprinc.org/materials.htm.

[3] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.



The Chronic Care Model has been successfully implemented in settings serving uninsured patients, the homeless, migrants, and minority populations, often using the Model for Improvement promulgated by the Institute for Healthcare Improvement.[4] Asthma disproportionately affects African-American, Latino, and low-income communities, so the prison population is adversely at risk. Even so, it is a chronic condition that can be proactively managed using evidence-based clinical guidelines within a chronic care framework.

The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. More than that, however, it will provide a testing ground for implementation of interdisciplinary quality improvement (QI) projects. It will engage all six of the organizational change strategies that the Institute of Medicine considers necessary to improve health care: (a) redesign of care processes based on best practices; (b) use of information technology for clinical information and support for caregivers; (c) increasing and deepening clinical knowledge and skills (d) development of a team-based, rather than a physician-centric, delivery system; (e) coordination of care; and (f) incorporation of performance and outcome measurements for improvement and accountability. The Asthma Initiative will demonstrate how to use data to inform the clinical care process while orienting our providers and management staff to patient safety issues. The end result of this specific disease management initiative will be a heightened awareness of chronic disease management leading to the improved care of other conditions and the beginning of a safety culture.

[4] See: How to Improve at www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprov.

C. Asthma Initiative Design

The new National Asthma Education and Prevention Program Expert Panel Report (Update 2007)[5] calls for interventions and measures within four broad components of care: (1) assessment and monitoring, both initial and periodic, including classification by severity; (2) education for a partnership in asthma care, including use of individual patient action plans; (3) control of factors contributing to asthma severity, and (4) pharmacotherapy.

Developing a medication guideline through the Pharmacy and Therapeutics Committee was a relatively easy first step. Educating the CDCR clinicians on the guideline will be more of a challenge, given the current lack of an effective education infrastructure. Education alone, however, is not likely to produce significant improvements in clinical outcomes.

The focus of the Asthma Initiative will be full-fledged, real-world practice redesign. The initiative leaders and ground-level clinicians must work together to address a multitude of issues to redesign the processes of care. For example, there is no mystery with regard to the need to assess the breathing capacity of asthma patients at each visit, but in the CDCR there is no agreement as to how to do so. Who will do the assessments, and how? Who will do the documentation, and how should verbal communication occur between patient and nurse, nurse and physician, physician and patient? What is the role of a respiratory therapist? How can we assure that information flows from on-site urgent care, off-site emergency department, or off-site consultant back to the yard clinic at the next appointment? More specifically, how should we address these questions now—in a system with chaotic medical records, pharmacies and laboratories, in which nurses and physicians have rarely worked together in teams, and in which custody and healthcare staff have often worked at cross purposes?

In order to achieve significant practice change and clinical improvement, the Asthma Initiative will involve headquarters, regional, and institutional staff, pharmacy/Maxor staff, and the external clinical and organizational change consultants. The local interdisciplinary teams will include provider, nursing, pharmacy, health records, and clerical staff. Each local interdisciplinary team will be led by a clinical champion well-respected by his/her peers. The external clinical change experts will provide a change package, project management, and QI technical support. The project will follow established clinical guidelines. The pharmacy information system will identify patients using asthma medications. Data on medication usage will help stratify patients by severity.

[5] NIH National Asthma Education and Prevention Program. Expert panel report 3: guidelines for the diagnosis and management of asthma. 2007. Available at http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.

The contractor team may want to propose using an adaptation of the original Breakthrough Series Learning Collaboratives.[6] Adaptations of the collaborative model have proven to be effective and efficient.[7]

The contractor team should consider engaging a small number of facilities initially, but staff from all 33 prisons should have the opportunity to participate in the initiative within a year. Under this scenario, the initial Asthma Initiative sites would be selected based on local leadership capacity, organizational resource availability, pharmacy stability, and prior implementation of a pharmacy information system, all factors that will also contribute to success in the Asthma Initiative. The pilot sites chosen will have been exposed to QI tools and process redesign; therefore, these sites are most likely to embrace a QI collaborative pilot and the chronic care model.

Although the CDCR's 33 prisons often differ in their patient populations, organizational cultures, and clinical effectiveness, they share a core set of policies and procedures. Their limited heterogeneity and autonomy should allow faster dissemination of practice improvement than could be achieved among separate organizations.

D. Aim, Goals, and Measures

The Asthma Initiative aims to eliminate preventable patient deaths due to undiagnosed or uncontrolled asthma. The initiative will improve asthma care by engaging physicians, nurses, pharmacists, and patients in implementation of the chronic care model using proven methods of organizational change.

At a minimum, the contractor team is to address the following outcomes and outputs with work plans including strategies, time lines, and accountabilities (responsible parties):

1. Design and direct a quality initiative to achieve evidence-based asthma care in the CDCR, encompassing practice redesign, clinical guidelines, policies, documentation tools, and staff education resources.
2. Develop culturally and linguistically appropriate education resources and collaborate with CDCR on appropriate peer education programs for patients with asthma.
3. Develop and lead implementation of a chronic care team model appropriate for corrections, delineating roles, responsibilities, and measures of team function in the asthma context.
4. Design and pilot an implementation plan for a disease registry, care coordination, and case management for patients with asthma.
5. Develop process improvement methodologies within the CDCR including use of quality measures, rapid-cycle quality improvement, and high-reliability practices in the asthma context.

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[6] The Breakthrough Series: IHI's Collaborative model for achieving breakthrough improvement. (2003) Boston, Massachusetts: Institute for Healthcare Improvement.
[7] Gould DA, et al. New York City Palliative Care Quality Improvement Collaborative. *Joint Commission Journal on Quality and Safety*. 2007: 33;307.

E. Work Plan

Applicants should submit a work plan consistent with the above aim, goals, and strategies. The work plan should include the proposed clinical measures and details as to how the contractor will use and/or adapt the Breakthrough Series model, as well as the proposed schedule, metrics, evaluation, key staff, budget, and contractor qualifications.

F. Organization and Direction

The contractor will work at the direction of the Receiver or the Receiver's designee. All work of contractor's staff will be at the day-to-day direction of a Project Executive or Project Director designated by the contractor.

IV. DELIVERABLES

The deliverables required will be stipulated in conjunction with the approved goals, measures, work plan, and associated staffing plans and schedules. **ALL DELIVERABLES CREATED BY THE CONTRACTOR UNDER THE AGREEMENT, WHETHER OR NOT IDENTIFIED AS CONTRACTUAL DELIVERABLES, WILL BE THE PROPERTY OF THE RECEIVER.**

V. SELECTION AND CONTRACTING PROCESS

An Evaluation Committee (the "Committee") will review the submitted proposals in accordance with submittal requirements and evaluation criteria set forth below and will recommend to the Receiver a short list of firms for further consideration. Upon acceptance of the short list, the Receiver may invite short-listed firms to make oral presentations to the Committee.

If the Receiver elects to conduct oral interviews, the entire proposed Key Staff of any short-listed teams must be available to participate in these interviews. The Committee will then make a final evaluation and submit its recommendation to the Receiver. The Receiver will make a final determination and authorize negotiations with one or more of the firms that have submitted their qualifications and whose responses are most advantageous to the Receiver.

The Receiver reserves the right to seek clarification of information submitted in response to this RFP and/or request additional information during the evaluation process. The Receiver reserves the right to accept or reject any or all qualifications and selections when it is determined, in the sole discretion of the Receiver, to be in the best interest of the Receiver.

The Receiver intends to negotiate and enter into a services agreement ("the Agreement") with the selected Respondent promptly upon selection. Prior to commencing the Services, the selected contractor must sign the Agreement and provide proof of insurance. The Agreement will include the Standard State Terms And Conditions set forth at:

http://www.cprinc.org/docs/special/STATE_REQUIRED_TERMS_AND_CONDITIONS_FOR_CONTRACTS.pdf

The Agreement is anticipated to be for a period of not more than 18 months.

VI. EVALUATION CRITERIA

The Committee will review Proposals in accordance with the following criteria:

A. Respondent's proven experience, capabilities and resources, at both the corporate and individual levels, in providing consulting and technical assistance services to programs comparable in size, scope of work, and urgency.

B. Qualifications, availability and commitment of key staff. Respondents shall clearly identify the key staff that will perform each of the above-described areas of scope, what role each is anticipated to fulfill in connection with the Project, and what percentage of their time will be devoted exclusively to this Project.

C. Proven systems, management techniques, required expertise and resources designed to facilitate timely and effective decision-making and stakeholder coordination.

D. Cost or relative value of services provided.

E. Completeness and comprehensiveness of response to this RFP and compliance with the submittal requirements.

F. Quality of oral interviews including technical analysis and presentation (if requested by the Receiver).

G. Legal actions that might affect Respondent's ability to perform as contracted.

H. Absence of any relationship that could constitute a conflict of interest or otherwise impede the ability of the Respondent to protect the interests of the Receiver.

VII. SUBMITTAL REQUIREMENTS

A. RFP Schedule

Event	Date
RFP Issued	October 24, 2007
Bidders' teleconference	November 8, 2007
Deadline for questions regarding RFP	November 13, 2007
Responses to questions	November 19, 2007
Proposals due	December 7, 2007
Notification for interviews	December 12, 2007 (estimated)
Interviews	December 17-21, 2007 (estimated)
Selection announced	January 3, 2008 (estimated)
Estimated project start date	January 21, 2008 (estimated)

B. Addenda

Any questions regarding the RFP should be submitted to CPR in writing. CPR will, at its discretion, respond to questions in an addendum. Any necessary information not included in this RFP that CPR deems necessary and relevant to responding to the RFP will also be issued in an addendum. CPR makes no guarantee that all questions submitted will be answered.

Addenda will be sent to all known applicants. If the Respondent did not receive this RFP directly from CPR, notify CPR in writing of a request to receive any addenda by November 19, 2007.

C. Format

Proposals should be clear, concise, complete, well organized and demonstrate both Respondent's qualifications and its ability to follow instructions.

8 (eight) bound copies of the Proposal should be provided, with all materials spiral bound into books of approximately 8-1/2" x 11" format, not to exceed forty (40) single-sided pages total length. At least one (1) copy must contain original signatures and be marked ORIGINAL.

Pages must be numbered. We will not count, in the total, the graphic cover sheet, cover letter, table of contents, blank section dividers (tabs), explanations about legal actions, and a maximum of 12 resumes, which may be included in an appendix. The entire Proposal shall also be submitted in electronic (pdf) format on CD, organized in the same manner as the printed submissions.

The Proposal shall be placed in a sealed envelope with the submitting firm's name on the outside of the envelope.

All respondents are requested to follow the order and format specified below. Please tab each section of the submittal to correspond to the numbers/headers shown below.

Respondents are advised to adhere to submittal requirements. Failure to comply with the instructions of this RFP may be cause for rejection of submittals.

The Receiver reserves the right to waive any informalities in any submittal and/or to reject any or all submittals. The Receiver reserves the right to seek clarification of information submitted in response to this RFP during the evaluation and selection process. The Committee may solicit relevant information concerning the firm's record of past performance from previous clients or consultants who have worked with the Respondent.

D. Contents

The Proposal must include the following items:

1. A cover letter signed by an officer of the firm submitting the Proposal, or signed by another person with authority to act on behalf of and bind the firm. The cover letter must contain a commitment to provide the required Services described with the personnel specified in the submission. The letter should certify that the information contained in the Proposal is true and correct. Please also indicate the contact person(s) for the selection process along with contact information.

2. Executive Summary: The Executive Summary must include a clear description of the primary advantages of contracting with your organization. It should also include a brief explanation of how the Respondent satisfies the evaluation criteria, and a brief statement that demonstrates Respondent's understanding of the desired Services.

3. Demonstration of the Respondent's Qualifications: Please provide the following information:

    a) Your company's name, business address and telephone numbers, including headquarters and local offices.

    b) A brief description of your organization, including names of principals, number of employees, longevity, client base, and areas of specialization and expertise.

    c) A description of your company's prior experience related to correctional and healthcare facilities.

    d) A description of your company's prior experience in California.

e) A description of your company's specific areas of technical expertise as they relate to this RFP.

f) A description of your company's internal training and quality assurance programs.

4. Professional references: Describe previous work on no more than three projects of comparable scope and magnitude for which you provided similar types of services. Provide complete reference information including project name, location, client, total contract amount (and firm's amount if different), principal-in-charge, day-to-day technical project director/manager, key staff, date completed, client reference (name, current position and phone number), and a brief narrative of project description for each project identified and described above. **Experience may not be considered if complete reference data is not provided or if named client contact is unavailable or unwilling to share required information.**

5. Qualifications of Technical Personnel: Submit current resumes for Key Personnel committed to this project and a statement regarding their local availability. Specifically describe previous related experience, its pertinence to this program, and provide references including the name, address and telephone number of a contact person who can verify the information provided. Provide brief description of referenced project(s), as well as any professional certifications, accreditation, special licensing or other qualifications which qualifies the professional to perform in their designated area of responsibility.

6. Legal action: Respondent must provide a listing and a brief description of all material legal actions, together with any fines and penalties, for the past five (5) years in which (i) Respondent or any division, subsidiary or parent company of Respondent, or (ii) any member, partner, etc., of Respondent if Respondent is a business entity other than a corporation, has been:

a) A debtor in bankruptcy;

b) A defendant in a legal action alleging deficient performance under a services contract or in violation of any statute related to professional standards or performance;

c) A respondent in an administrative action for deficient performance on a project or in violation of a statute related to professional standards or performance;

d) A defendant in any criminal action;

e) A principal of a performance or payment bond for which the surety has provided performance or compensation to an obligee of the bond; or

f) A defendant or respondent in a governmental inquiry or action regarding accuracy of preparation of financial statements or disclosure documents.

7. Default Termination: Disclosure whether your company has defaulted in its performance on a contract in the last five years, which has led to the termination of a contract.

8. Conflict of Interest: Identify any existing financial relationships with other contractors that may be a part of your proposal, and explain why those relationships will not constitute a real or perceived conflict of interest.

9. Cost Proposal: Provide a cost proposal for performing the Services.

E. Modification or Withdrawal of Proposal.

Prior to the Proposal due date, Respondents may modify or withdraw a submitted Proposal. Such modifications or withdrawals must be submitted to CPR in writing. Any modification must be clearly identified as such and must be submitted in the same manner as the original (e.g., appropriate copies, paper size, etc.). No modifications or withdrawals will be allowed after the Proposal due date.

F. Public Opening

There will be no public opening of responses to this RFP. However, after a contract is awarded all Proposals may be available for public review. CPR makes no guarantee that any or all of a Proposal will be kept confidential, even if the Proposal is marked "confidential," "proprietary," etc.

G. General Rules

1. Only one Proposal will be accepted from any one person, partnership, corporation or other entity.

2. Proposals received after the deadline will not be considered.

3. This is an RFP, not a work order. All costs associated with a response to this RFP, or negotiating a contract, shall be borne by the Respondent.

4. CPR's failure to address errors or omissions in the Proposals shall not constitute a waiver of any requirement of this RFP.

H. Reservation of Rights

The Receiver reserves the right to do the following at any time, at the Receiver's discretion:

1. Reject any and all Proposals, or cancel this RFP.

2. Waive or correct any minor or inadvertent defect, irregularity or technical error in any Proposal.

3. Request that certain or all candidates supplement or modify all or certain aspects of their respective Proposals or other materials submitted.

4. Procure any services specified in this RFP by other means.

5. Modify the specifications or requirements for services in this RFP, or the required contents or format of the Proposals prior to the due date.

6. Extend the deadlines specified in this RFP, including the deadline for accepting Proposals.

7. Negotiate with any or none of the Respondents.

8. Terminate negotiations with a Respondent without liability, and negotiate with other Respondents.

9. Award a contract to any Respondent.

Inquiries in regard to this RFP should be addressed to:

Terry Hill, M.D., Chief Medical Officer
1731 Technology Drive, Suite 700
San Jose, CA 95110
terry.hill@cprinc.org

CERTIFICATE OF SERVICE

The undersigned hereby certifies as follows:

I am an employee of the law firm of Futterman & Dupree LLP, 160 Sansome Street, 17th Floor, San Francisco, CA 94104. I am over the age of 18 and not a party to the within action.

I am readily familiar with the business practice of Futterman & Dupree, LLP for the collection and processing of correspondence.

On November 20, 2007 I served a copy of the following document(s):

DECLARATION OF TERRY HILL, M.D. IN SUPPORT OF RECEIVER'S SUPPLEMENTAL APPLICATION NO. 2 FOR ORDER WAIVING STATE CONTRACTING STATUTES, REGULATIONS AND PROCEDURES, APPROVING RECEIVER'S SUBSTITUTE PROCEDURE FOR BIDDING AND AWARD OF CONTRACTS

by placing true copies thereof enclosed in sealed envelopes, for collection and service pursuant to the ordinary business practice of this office in the manner and/or manners described below to each of the parties herein and addressed as follows:

___ BY HAND DELIVERY: I caused such envelope(s) to be served by hand to the address(es) designated below.

_X_ BY MAIL: I caused such envelope(s) to be deposited in the mail at my business address, addressed to the addressee(s) designated. I am readily familiar with Futterman & Dupree's practice for collection and processing of correspondence and pleadings for mailing. It is deposited with the United States Postal Service on that same day in the ordinary course of business.

___ BY OVERNIGHT COURIER SERVICE: I caused such envelope(s) to be delivered via overnight courier service to the addressee(s) designated.

___ BY FACSIMILE: I caused said document(s) to be transmitted to the telephone number(s) of the addressee(s) designated.

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Dated: November 20, 2007

Lori Dotson